Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Gilbert Cedillo
Senator Tom McClintock
Senator Bruce McPherson
Senator Deborah Ortiz

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2:30 PM or Upon Adjournment of Session

Room 4203

(Diane Van Maren, Consultant)

Item	*Description*
4440	**Department of Mental Health**

- **Community-Based Mental Health**
- **State Hospitals**

I. 4440 Department of Mental Health

Overall Purpose and Description of the Department

The Department of Mental Health (DMH) administers the Bronzan-McCorquodale and Lanterman-Petris-Short Acts providing delivery of mental health treatment services through **(1)** a state-county partnership and **(2)** the involuntary treatment of the mentally-disabled. The DMH is responsible for the operation of five state hospitals and the acute psychiatric units at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

Overall Budget of the Department

The budget proposes expenditures of $2.319 billion ($786.8 million General Fund) for mental health services. This reflects a decrease of $60.2 million, or 7 percent, over the revised 2002-03 budget. Of the total amount, $1.588 billion is for local assistance, $693.1 million is for the state hospitals, $19.3 million is for department support, and $6 million (General Fund) is for state mandated local programs.

In addition, it is estimated that $1.095 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget.

Further, an appropriation of $21.5 million ($736,000 General Fund and $20.8 million Public Building Construction Fund) is provided for capital outlay purposes.

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Program Source				
Community Services Program	$1,577,648	$1,625,631	$47,983	3
Long Term Care Services	659,608	693,121	$33,513	5
State Mandated Local Programs	6	6		
Total, Program Source	$2,237,262	$2,318,758	$81,496	3.6
Funding Source				
General Fund	$846,960	$786,789	($60,171)	
Federal Funds	60,834	60,839	5	
Reimbursements	1,325,684	1,467,919	142,235	
Other Funds	3,784	3,211	(573)	
Total Department	$2,237,262	$2,318,758	$81,496	

A. Community-Based Mental Health Services

Summary of Funding

State Funding: **The budget proposes expenditures of almost $1.588 billion ($224.3 million General Fund) for community-based local assistance, including the Conditional Release Program.** This reflects an increase of $131.9 million (total funds) and a reduction of $95.9 million (General Fund) as compared to the revised 2002-03 budget.

Realignment Funding: **In addition, it is estimated that $1.095 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget.** This estimate is based on the following revenue estimates:

- Sales Tax $820,568,000
- Vehicle License Fee Account $265,784,000
- Vehicle License Fee Growth Account $8,718,000
- Sales Tax Growth Account $-0-

Realignment revenues deposited in the Mental Health Subaccount, as established by formula outlined in statute, are distributed to counties until each county receives funds equal to the previous year's total. Any realignment revenues above that amount are placed into a growth account. Generally, first claim on the distribution of growth funds are caseload-driven social services programs. Any remaining growth (i.e., "general" growth) in revenues is then distributed according to a formula in statute.

Concerns with Lack of Growth Funds: As discussed in a recently released report on mental health realignment (AB 328 Realignment Data, Department of Mental Health, February 5, 2003), **due to continued caseload growth in Child Welfare services and Foster Care, as well as cost increases in the In Home Supportive Services (IHSS) Program, growth distributions to the Mental Health Subaccount and Health Subaccount have been substantially reduced. This is because the first claim on the Sales Tax Growth Account goes to caseload-driven social services programs, not the Mental Health Subaccount.**

ITEMS FOR DISCUSSION—COMMUNITY MENTAL HEALTH

1. Unmet Mental Health Needs in California—*Informational Item*

Assessing Mental Health Needs in California—600,000 People in Unmet Needs: A comprehensive analysis of "**unmet" need has been recently conducted by the California Mental Health Planning Council (Council) (Report dated March 2003).** They reviewed a number of methodologies for estimating how many people need public mental health services and **worked with the California Mental Health Directors Association (CMHDA) and the Department of Mental Health (DMH) for *more than a year* to develop these estimates.**

According to the Council's Report, they believe that a reasonable estimate of unmet need for public mental health services is about *600,000 persons*. To put this figure in perspective, about 460,000 persons were served in the public mental health system in 1997-98. **Therefore, the public mental health system would need to more than double to meet the needs of all children and youth with serious emotional disturbances and adults and older adults with serious mental illness.**

"Unmet" need reflects the number of people who are not getting any mental health services at all. It does not reflect the number of people who are underserved.

Summary of Unmet Need Estimates of Age Group

Age Group	Lower Limit CMHS (1)	Lower Limit CMHS (2)	Lower Limit Meinhardt (1,3)	Lower Limit Meinhardt (2,3)
0-17	123,592	271,978	123,592	271,978
18-20	28,888	28,888	33,339	33,339
21-59	191,913	191,913	239,963	239,963
60+	92,042	92,042	104,164	104,164
Lower Total	**436,435**	**584,821**	**501,058**	**649,444**
Age Group	**Upper Limit CMHS (1)**	**Upper Limit CMHS (2)**	**Upper Limit Meinhardt (1,3)**	**Upper Limit Meinhardt (2,3)**
0-17	493,593	864,000	493,593	864,000
18-20	76,889	76,889	87,925	87,925
21-59	699,403	699,403	820,316	820,316
60+	225,145	225,145	254,916	254,916
UPPER Total	**1,495,030**	**1,865,437**	**1,656,750**	**2,027,157**

CMHS—federal Center for Mental Health Services.
(1) Unmet need for 0-17-year-olds is calculated based on children with SED and extreme functional impairment.
(2) Unmet need for 0-17-year-olds is calculated based on children with SED and substantial functional impairment.
(3) Meinhardt's estimates to do not apply to 0-17-year-olds. In order to estimate total unmet need for all age groups, Meinhardt's prevalence rates were used for transition-age youth, adults, and older adults, and CMHS figures have been used for the 0-17-year-olds.

The Council notes that any method for estimating "unmet" need has limitations that must be carefully considered when evaluating the results of the study, **including the following key considerations:**

- Due to a variety of factors, including **human resource shortages, geographic location, population growth rates and socioeconomic status, some counties have more difficulty providing services to their persons in need.**
- **Ethnic populations may be hesitant to report mental illness and to seek services.**
- **The Serious Emotional Disturbance prevalence rates used apply to children from 9 to 17 years of age only.** Generally, data are presently inadequate to estimate for children under the age of nine. However, some studies have suggested prevalence rates of 7 to 22 percent for younger children. **Therefore, the Council's methodology most likely provides a conservative estimate for this age group.**
- The data used for both the Meinhardt and CMHS are derived from household surveys. **As a result, they exclude the homeless and people in nursing homes, military barracks, correctional institutions, hospitals and residential facilities for persons who are mentally ill or mentally retarded.**

Subcommittee Request and Questions: The Subcommittee has requested **Ms Ann Arneill-Py**, Executive Director of the California Mental Health Planning Council, **to provide an overview of their unmet needs analysis.**

Budget Issue: No action is required. This is an informational item.

2. Report on Realignment Data As Required by Chapter 367/2001 (February 2003)

Summary of Mental Health Funding— Historically Under Funded: As noted by the DMH in public testimony before the Little Hoover Commission, **limited funding of the existing public mental health system is the foremost limiting factor in providing adequate services.**

In reviewing past funding patterns, this has been generally true historically. According to a 1990 report by the California Mental Health Directors Association**, between 1975 and 1990 the mental health system experienced an erosion of about $320 million due to unfunded client population growth and increases in the cost of providing services. Since mental health services were never established as an "entitlement", it made it difficult for these services to compete for state General Fund moneys during a time of economic recession and diminishing state revenues.**

Background—Realignment Significantly Changes Governance Structure and Funding: AB 1288 (Bronzan and McCorquodale), Statutes of 1991, realigned the fiscal and administrative responsibility under county authority. **The intent of mental health realignment was generally to:**

- Provide a more stable funding source for community-based services;
- Shift program accountability to the local level (counties and two cities);
- Provide counties with additional flexibility regarding the use of mental health funds for those receiving services from the county;
- Establish local advisory boards in each county to provide advice to local mental health directors;
- Make services more client centered and family focused;
- Develop performance measures and outcome data;
- Redefine the role of the state in providing services through the State Hospital system and its responsibilities in program oversight and evaluation.

Background--Realignment Funding: **In 1992, Realignment funding replaced about $700 million in state General Fund support for community mental health services.** Realignment revenues, funded by an increase in the Sales Tax and in vehicle license fees, are collected by the state and allocated to various accounts and subaccounts in the Local Revenue Fund. **The Mental Health Subaccount is the principal fund that contains revenues for the provision of local mental health services.**

It should be noted that due to a decrease in revenues (sales tax and vehicle license fees) in 1991-92, realigned services were not funded initially at the 1990-91 levels. Counties only received $668 million—about $82 million less than the actual expenditures for realigned services in mental health services in 1990-91. **As noted in the Report on Realignment, funding levels finally met the 1990-91 levels in 1994-95 (the fourth year of Realignment).**

In addition, realignment funding was based on the current funding going to each county at the time of implementation and did not take into consideration the adequacy of funding prior to 1991.

Realignment revenues deposited in the Mental Health Subaccount, as established by formula outlined in statute, are distributed to counties until each county receives funds equal to the previous year's total. Any realignment revenues above that amount are placed into a growth account. Generally, first claim on the distribution of growth funds are caseload-driven social services programs. Any remaining growth (i.e., "general" growth) in revenues is then distributed according to a formula in statute.

It is estimated that $1.095 billion will be available in the Mental Health Subaccount (County Realignment Funds) for 2003-04. These funds do not directly flow through the state budget because they are county funds.

Concerns with Lack of Growth Funds: As discussed in report, **due to continued caseload growth in Child Welfare services and Foster Care, as well as cost increases in the In Home Supportive Services (IHSS) Program, growth distributions to the Mental Health Subaccount and Health Subaccount have been substantially reduced. This is because the *first claim on the Sales Tax Growth Account goes to caseload-driven social services programs, not the Mental Health Subaccount.***

Background--Realignment Target Population: **The statute also defined appropriate use of these funds and established definitions for priority target populations to help focus how resources are spent. Specifically, counties are required to provide services to individuals who have a severe mental illness or serious emotional disturbance, *to the extent that resources are available*.** The criteria include diagnoses with psychotic features, serious functional impairment, risk of hospitalization, and risk of removal from home (mainly for children). **There are no income eligibility provisions; therefore, individuals with assets are charged fees according to an established schedule.**

Background—Impact of Medi-Cal on the Mental Health System Since Realignment: As noted in the Report on Realignment, **the second largest revenue source for county mental health programs is Federal Medicaid (Medi-Cal) dollars.** As noted in the Report on Realignment, understanding the changes in the state's Mental Health Managed Care Program ***since* Realignment and the interaction of the Medi-Cal revenues with Realignment are critical to analyzing the current structure** and status of public mental health services in California.

Following Realignment, counties were *mandated* to serve the Medi-Cal population who meet medical necessity criteria and counties were making an effort to assist clients in getting on Medi-Cal since this provided additional federal dollars. Realignment replaced the state General Funds that were previously used to draw the federal Medicaid match.

Key Findings of Report on Realignment Data (February 2003) as Required by Statute: AB 328 (Salinas), Statutes of 2001 directed the DMH to report to the Legislature regarding three areas of **mental health financing and service delivery since Realignment—revenues, services and expenditures.**

Key Findings—REVENUES *&* EXPENDITURES

- Under the current funding structure, **funds appropriated to the counties under Realignment have not kept pace** with 1991-92 levels when population changes and medical inflation are taken into account (page 30). The percentage increase in medical inflation and client growth combined **has been greater than the increase in realignment revenues.**
- Increased **federal funding has provided some revenue assistance; however, many counties must use an increasing proportion of their Realignment funds to draw the federal Medicaid (Medi-Cal) match. As such, they have decreased the amount of funds expended for indigent clients** (page 30). Specifically, three major changes have increased the availability of federal funding:
    - Implementation of the Rehabilitation Option which added certain mental health services available under the Medi-Cal Program (with no state General Fund affect);
    - Consolidation of the Fee-For-Service Program into the Mental Health Managed Care Program; and
    - Expansion of Medi-Cal services to children under 21 years of age under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program;
- **Mental health programs are not able to continue to generate sufficient revenues to keep pace with increased client and service usage and increases in expenditures for services. The Report notes that the number of clients served and expenditures for services for these clients have both risen dramatically over the last ten years.**
- Total mental health expenditures have increased 72 percent since the enactment of Realignment. This is due to many factors, including medical inflation (as calculated by the DMH and federal CMS), increased acuity of clients and their service usage, and other factors such as housing and staffing costs.

Key Findings—SERVICES *&* SERVICE DELIVERY

- Counties have been **able to reduce inpatient services and use these cost savings to increase access and create more appropriate and less restrictive community treatment services.** County flexibility has further allowed counties to institute best practices, which appear to be more effective in the recovery process for individuals with severe mental illness and serious emotional disturbances.
- The number of **Medi-Cal clients served increased 131 percent over the 10 year period**, while numbers of indigent clients served decreased by about 8 percent. **This resulted in a shift in the balance between Medi-Cal and indigent clients:**
    - 45 percent Medi-Cal to 55 percent indigent clients in 1990-91.
    - 68 percent Medi-Cal to 32 percent indigent clients in 1999-2000.

This shift is probably mainly due to the fact that following Realignment, counties were mandated to served the Medi-Cal population who meet medical necessity criteria and counties are making an effort to assist clients in getting on Medi-Cal since this provided additional federal dollars.

- **Usage of services for individuals with severe mental illness and serious emotional disorders has been increasing.** This is reflected both in increasing numbers of clients served and the increasing intensity of services provided per client.
- The growth in services for children and youth has been greater than for adults.

Subcommittee Request and Questions: The **Subcommittee has requested representatives from the counties, the DMH and other interested parties to respond to the following questions or to offer general public comment and observation:**

- **1. Counties**, From your perspective what key aspects of the report are of note to you from either a policy or fiscal perspective? Do you have any suggestions for improvements?
- **2. DMH**, What is your perspective of the information? Do you have any suggestions for improvements?
- **3. LAO,** What is your perspective of the information?

Budget Issue: No action is required. This is an informational item.

3. Mental Health Managed Care—ISSUES "A" to "E"

Overall Background—Overview of Mental Health Managed Care: Implementation of Medi-Cal Mental Health Managed Care has included the consolidation of Medi-Cal psychiatric inpatient hospital services ("Phase I"), which occurred in January 1995 and the consolidation of Medi-Cal specialty mental health services ("Phase II"), which occurred from November 1997 through June 1998. **These two phases of implementation consolidated the two existing Medi-Cal mental health programs (Short-Doyle and Fee-For-Service) into one service delivery system. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government (i.e., HCFA, now the Centers on Medicare and Medicaid—CMS).**

Under this delivery system, psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists, and some nursing services**, became the responsibility of a single entity, the Mental Health Plan (MHP) in each county. Medi-Cal recipients *must* obtain services through the MHP.**

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality.

Under this model, **MHPs generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. An annual state General Fund allocation is also provided to the MHP's.**

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

The DMH is responsible for monitoring and oversight activities of the MHPs to ensure quality of care and to comply with federal and state requirements.

ISSUE "A"—Status of the Federal Waiver Renewal & Emergency Regulations

Background—Status of Waiver Still Pending: California is currently operating under a temporary extension of the Medi-Cal Mental Health Managed Care Waiver (Waiver). **Our existing two-year Waiver expired as of November 2002 but the state has been obtaining 90-day extensions to continue existing operations. The latest 90-day extension (the second) provides operation *through May 19, 2003*. According to both the DHS and DMH, it is anticipated that the CMS will approve California's Waiver.**

In order to renew our Waiver, the state had to submit a required "Independent Assessment" of the Waiver, submitted to the federal CMS in November 2002, as well as provide additional information in response to questions asked by the CMS.

Background—Emergency Regulation Authority Is Never Ending: Effective **November 1, 1997,** the DMH adopted emergency regulations for Medi-Cal Mental Health Managed Care as provided for in Section 5775 of Welfare and Institutions Code. However, this authority was **never intended to be on-going.**

Since this time, the DMH has obtained authority to continue the emergency regulations through annual Budget Act Language, including language adopted in 1998, 1999, 2000, 2001 and 2002. This authority will expire as of June 30, 2003, unless action is taken to extend this authority.

The DMH has **had two public comment periods on the emergency regulations—November 1997 to January 1998, and November-December 1999.** According to the DMH, extensive public comment was received.

Governor's Proposed Budget—Budget Bill Language and Trailer Bill Language (See Hand Out): **The Governor's proposed budget contains Budget Bill Language for the purpose of extending the emergency regulation authority to July 1, 2004. Specifically, the proposed language is as follows:**

> "Notwithstanding any other provision of law, the emergency regulations adopted pursuant to Section 14680 of the Welfare and Institutions Code to implement the second phase of Mental Health Managed Care as provided in Part 2.5 (commencing with Sections 5775) of Division 5 of the Welfare and Institutions Code shall remain in effect **until July 1, 2004**, or until the regulations are made permanent, whichever occurs first, and shall not be subject to the repeal provisions of Section 11346.1 of the Government Code until that time."

Subcommittee Request and Questions: The Subcommittee has **requested the DMH to respond to the following questions:**

- **1.** Please provide **an update on the status of the emergency regulations for Medi-Cal Mental Health Managed Care**. **Why has the process taken so long?**
- **2. What else needs to be done to complete the normal regulation process?**
- **3.** Please provide an **update on the status of the Waiver.** What else needs to be done to complete the Waiver process?

Subcommittee Staff Recommendation: It is recommended **to delete the Budget Bill Language as contained in the Governor's proposed budget and instead, utilize the Administration's proposed trailer bill language as requested for development of emergency regulations for the new federal regulations (See Agenda, ISSUE "C", below).**

Further it is recommended for the Administration (DMH and DHS) to keep the Subcommittee informed as to the (1) progress of completing the entire package of Medi-Cal Mental Health Managed Care regulations, and **(2)** ongoing discussion with the federal CMS and approval of the state's Waiver for Medi-Cal Mental Health Managed Care.

Budget Issue: Does the Subcommittee want to adopt the staff recommendation or another option?

ISSUE "B"—Discussion of the "Independent Assessment" for Waiver Renewal

Background—What is the Independent Assessment: The federal CMS **requires states to submit "Independent Assessments" of their Waivers in order to determine (1) client access to services, (2) quality of services, and (3) the cost effectiveness/neutrality. An Independent Assessment must be conducted and provided to the federal CMS every two years, prior to Waiver renewal.**

The Department of Finance, Office of State Audits and Evaluations Unit, entered into an interagency agreement with the DHS (as the sole Medicaid Agency) to perform the Independent Assessment of the Waiver. The DHS, in consultation with the DMH developed and provided the DOF unit with a proposed work plan.

The DOF conducted their assessment in several phases over a six-month period. They met with over 100 county representatives, conducted County MHP site visits, spoke with seven clients and provider advocacy groups, and meet with various DMH representatives. They also reviewed other supplemental documentation to familiarize themselves with the current implementation of the Waiver program**. In addition, 139 chart reviews of clients were conducted and 23 provider sites were visited.**

The DOF notes in their analysis that they also performed a limited fiscal review to determine whether claimed billings were supported by source documentation.

Key Findings of the Independent Assessment: The Independent Assessment looked at three key components—access to services, evaluation of quality, and cost-effectiveness analysis. **This report is about 120 pages; as such, key findings in each of these areas are noted below:**

Access to Services—Key Findings and Concerns *(Page iv of report)*

A key goal of the Waiver is to improve access to specialty mental health services for Medi-Cal clients. **The Independent Assessment evaluated four core access elements—gatekeeping functions, 24/7 emergent and urgent-care capacity, outreach to targeted and under-served populations, and availability of patients' rights and choice information.**

Based this evaluation, the DOF found that access for Medi-Cal clients has improved since the implementation of the Waiver and that advocacy groups believe that California would best be served by continuation of the Waiver.

However, the following areas of concern were also identified.

- **Uneven statewide provision of Medi-Cal reimbursable services**;
- Historical **inequitable County MHP funding bases and resulting effects on current utilization and penetration rates**;
- **Lack of standards governing provider capacity** and providers' self-assessment of capacity;
- **Insufficient numbers of hospital beds and step-down facilities**;
- Shortages of general ***and*** child psychiatric services and the **resulting appointment delays and waiting lists.**

Evaluation of Quality—Key Findings and Concerns *(Page iv of report)*

The Waiver is also intended to enhance quality of services. **The DOF looked at many elements regarding quality, including coordination of care, continuous care methodologies, cultural competence, credentialing provides and quality management programs. The DOF notes that quality of services has improved since the Waiver.**

However, the following areas of concern were also identified.

- **Barriers to overall coordinated care** include the disconnect between county-operated/contract and network fee-for-service providers, the inconsistent sharing of treatment results among providers, and the inconsistent provision of case management to mental health clients.
- **Inconsistent statewide ability to discharge clients to lower levels of care**, possibly resulting in increased inpatient readmission rates and hospital administrative days.

- **Inconsistent statewide methodologies and periodicity requirements** for preparation and update of assessments and client plans;
- **Inconsistent statewide scope of quality assurance systems**, especially pertaining to provider chart reviews;
- **Infrequent and inconsistent quality assurance monitoring** of provider charts, particularly of network fee-for-service providers.
- **Lack of state special incident reporting** system for outpatient services;

Evaluation of Quality—Key Findings and Concerns *(Page iv of report)*

The DOF determined **that the Waiver was cost effective/neutral** (meaning that more funds would have been spend had the Waiver not been implemented).

However, the following areas of concern were also identified.

- EPSDT costs are **not tracked by the County MHPs because the state requires no oversight of EPSDT expenditures.**
- The methodology used to calculate the federal CMS –approved cost effectiveness figure (referred to as "upper payment limit") is based only on historical trends and does not provide accurate estimates because actual data becomes obsolete, as unpredicted changes in the environment take place.
- EPSDT program costs represent 40 percent of overall Waiver costs.

Department of Finance, Evaluation Unit's Conclusions and Recommendations: Though overall the DOF concluded that the Waiver improved both access to and quality of services while maintaining cost-effectiveness/neutrality, **they also identified recommendations for areas that require consideration and analysis *by the DMH* to determine the most appropriate course of action. The DOF's recommendations included the following:**

DOF Conclusions and Recommendations *(Page vi of report)*

- **DMH should** promulgate regulations requiring an increased level of capacity monitoring for network fee-for-service providers to reduce the incidence of service delays;
- **DMH should** develop statewide guidelines and best practices to provide guidance and assistance to help ensure that County MHPs operate at optimal levels.
- **DMH should** draft a State Quality Improvement Plan to coordinate oversight efforts and support County MHPs.
- **DMH/DHS should** revise the methodology used to calculate the "Upper Payment Limit" and it should be performed by an actuary, or based on sound methodology, similar to that contained in the DHS Manual for Upper Payment Limits in health.

- **DMH should** enhance the existing special incident reporting system to include reportings on outpatient care.
- DMH should implement a plan for monitoring medication utilization trends in order to identify unusual fluctuations and promote appropriate use of resources.

Subcommittee Request and Questions: The Subcommittee has requested the DMH and DHS to respond to the following questions:

- **1.** What does the **DMH and DHS think of the Independent Assessment key findings?**
- **2.** Are there **any recommended changes** to Medi-Cal Mental Health Managed Care due to the findings **that the DMH is going to proceed with?**

ISSUE "C"—Implementation of New Federal Regulations for Waiver

Background—New Federal Regulations for Waiver: As discussed above, California's Medi-Cal Mental Health Managed Care Program operates under a federal Waiver. Our Waiver enables a County Mental Health Plan (MHPs) to limit client access to a specific pool of services and practitioners. The Waiver promotes MHP improvement in three significant areas—access, quality, and cost containment/neutrality.

New federal managed care regulations were issued in June 2002 and must be implemented by the state and MHPs by August 13, 2003. According to the DMH, the new regulations require significant changes in the operation of the program.

Specifically, the regulations would require the following:

- **1.** The DMH must arrange for **annual "External Quality Reviews" (EQRs)** of the quality outcomes and timeliness of access to services covered by **each MHP** (56 MHPs—there are two MHPs that cover two counties);
- **2.** The methodology used to **reimburse the MHPs must be validated annually by a qualified actuary**. The DMH notes that **the actuarial studies may result in the need to revise current methods since the method currently used for distributing state General Fund support to the MHPs is not actuarially determined.**
- **3.** The **state must provide extensive information to clients** about the MHPs and client rights available under the Waiver, including detailed explanations of federal regulations written in a language that can be easily understood by all clients.
- **4. The state must conduct expedited state fair hearings (a decision within three business days of filing) in situations in which a client may suffer harm** if the process follows the normal 90-day time frame. According to the DMH, there are about 100 mental health-related fair hearings per year and currently**, the hearing process frequently takes more than the allowed 90-days**. *(These costs are address in a DHS-*

related budget change proposal and will be discussed at a subsequent Subcommittee hearing.)

- **5. The County MHPs will be required to (a)** establish advance directive systems, **(b)** establish formal compliance plans and systems, **(c)** finalize and distribute informational materials, **(d)** comply with new administrative requirements related to provider contracts, **(e)** maintain additional documentation of the adequacy of the MHP's provider networks, **(f)**adopt formal practice guidelines, and **(g)** establish a more complex grievance and appeal system.

Generally, the state has three options for meeting the requirements of the regulations. We can either (1) fully comply, (2) request Waivers for certain provisions, or (3) restructure the existing program to meet all of the requirements.

Governor's Proposed Budget (See Hand Out): The budget proposes **an increase of $6.2 million ($1.7 million General Fund** and $4.5 million in reimbursements from the DHS—federal Medicaid funds) **and a two-year limited-term Associate Mental Health Specialist position to support federally required External Quality Reviews (EQRs)** of the County Mental Health Plans (MPHs) **and related activities** to ensure that the program is brought into compliance with new federal regulations.

In addition, the Administration is proposing trailer bill language to adopt *new* emergency regulations implementing the new federal requirements on an emergency basis because of the federal implementation timeline (August 13, 2003)

Of the amount proposed, (1) $5.6 million is for a contract to conduct EQRs of the MHPs, (2) $50,000 is for a contract to conduct an actuarial analysis, **(3)** $500,000 is for client information materials, and **(4)** $75,000 is for the position and related operating expenses.

The DMH states that the funding level for the EQR contract is modeled after the DHS contract which is used to conduct 20 EQRs (of Medi-Cal Managed Health Care Plans) along with certain other required studies. The DHS contract costs $2 million (total funds) annually; therefore, the comparison of using $5.6 million (total funds) is probably accurate, given that 36 more EQRs would need to be conducted.

The DMH states that the requested two-year limited-term position is needed to review and revise existing state and MHP systems to comply with the new regulations. Specifically, it would be used to review current state regulations, MHP contracts, DMH Letters to Counties and Information Notices, Waiver documents and other materials for compliance with the new federal regulations.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please provide **a brief description of the *key* components of the federal regulations.**
- **2. Please provide a brief description of the budget request.**

- **3. How are County MHPs affected by the new federal regulations?**
- **4. Does the DMH anticipate any other changes with respect to the new federal regulations that would require a change to the budget? If yes, please explain.**
- **5. Will these emergency regulations be done in tandem** with completing the emergency regulations for Medi-Cal Mental Health Managed Care overall?
- **6. Will the External Quality Reviews be made available to the public or Legislature upon request?**

Subcommittee Staff Comment: Subcommittee staff recommends approval of the request **except for the two-year limited-term position.** In lieu of the new position, it is recommended to re-direct a position from within the DMH for this purpose. **Savings of $75,000 ($37,500 General Fund) would be obtained by deleting the position.**

It is recognized that this is an important function that needs to be completed; however due to implementation timeframes (i.e., August 2003) it is unlikely that the DMH would be able to hire someone and have the activities accomplished. Further, DMH staff is working on this issue now and therefore, have been redirecting resources already for this purpose.

Budget Issue: Does the **Subcommittee want to** adopt the budget as proposed, including the trailer bill language, ***or*** require the DMH to redirect an existing position as recommended by Subcommittee staff for savings of $75,000 ($37,500 General Fund)?

ISSUE "D"—Governor's Proposed Reduction in Funding of Waiver

Background—State & County Realignment Funds Used to Draw Federal Match: As discussed above, the state's Mental Health Managed Care Program operates under a federal Waiver whereby County Mental Health Plans (MHPs) are responsible for the provision of public mental health services, including those for Medi-Cal recipients.

An annual state General Fund allocation is provided to County MHPs, though counties also use a substantial amount of County Realignment funds—Mental Health Subaccount--to draw down federal matching dollars. For example,

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

State General Fund Allocation: **The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI)for medical services, and other relevant cost items.**

***However,* the state's allocation is contingent upon appropriation through the annual Budget Act. As such in more difficult fiscal years, state General Fund support has *not* been provided for the medical CPI, or the base level of funding has been proposed for reduction (such as this year).**

Governor's Proposed Mid-Year Reduction: The Administration proposed a reduction of **$8 million ($4 million General Fund)** in the Mid-Year Reduction proposal for 2002-03. This proposal assumed a ten percent "provider rate" decrease effective April 1, 2003. **This proposal was denied by the Legislature.**

Governor's Proposed Budget: The budget proposes a total state General Fund appropriation of $207.1 million (General Fund) for allocation to the County MHPs to assist in funding the Waiver Program. **This reflects a *net* decrease of $12.2 million ($6.1 million General Fund)** in the amount the state provides to the counties for Mental Health Managed Care**. It should also be noted that the medical CPI is being funded** and has not been funded since the Budget Act of 2000; This equates to another $13.4 million ($6.7 million General Fund) loss to the County MHPs.

This net decrease consists of the following proposed *key* adjustments:

- **Decrease of $46 million ($23 million General Fund) in the base County allocation amount. The Administration is referring to this as a ten percent Medi-Cal provider rate reduction; however, it should be noted that the counties already negotiate rates with their providers so in real terms, it is a reduction to the County allocation.**
- **Increase of $12.4 million ($6.2 million General Fund) to reflect increased County MHP administrative costs** due to the implementation of the **new federal regulations**. *(This item was discussed in the above item of the agenda—See Issue "C".)*
- **No adjustment for the medical Consumer Price Index (CPI) was provided. According to the DMH, it would be about 3.4 percent in the budget year for an expenditure of $13.4 million ($6.7 million General Fund). It should be noted that the medical CPI has not been funded for Mental Health Managed Care since the Budget Act of 2000.**

Subcommittee Staff Comment: The proposed reduction will likely result in County MHPs serving fewer individuals and having difficulty in meeting statutory and contractual responsibilities related to the provision of Medi-Cal Mental Health Managed Care services.

As discussed under Issue "B" above, the state and the counties are having some difficulty in presently meeting needs and requirements. As noted in the Independent Assessment, the state needs to address numerous issues regarding client access to services, quality of services, performance outcome measures and program management functions.

Both the short-term and long-term effect of this action is to cost shift mental health services more to the counties. **This proposal continues the Administration's direction to substantially reduce General Fund support for mental health services, other than the State Hospitals. About $164 million (General Fund), or 34 percent of the General Fund, was reduced from community-based mental health services in the Budget Act of 2002.**

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please provide a **brief description** of the proposal.
- **2. From a policy perspective, does the DMH have concerns with reducing this program given the comments contained in the Independent Assessment?**

ISSUE "E"—Any DMH Efforts to Capture Additional Federal Funds?

Background: Generally, there **are three key ways that the public mental health system draws federal funds using a combination of state General Fund and County Realignment Funds as the state's Medicaid match. These three ways include: (1)** Medi-Cal Mental Health Managed Care Waiver, **(2)** the Rehabilitation Option, and **(3)** Early Periodic Screening Diagnosis and Treatment (EPSDT). Each of these areas enables California to draw one federal dollar for each state dollar (State General Fund and County Realignment Fund).

The Rehabilitation Option, implemented in 1993, opened Medi-Cal reimbursement eligibility to a wide range of licensed practitioners—psychiatrists, psychologists, licensed clinical social workers, and marriage, family and child counselors. Delivery of mental health services may be located in a variety of sites rather than in the traditional clinic setting. California has been able to draw down hundreds of millions in increased federal reimbursement through this option.

Potential Alternatives for Obtaining Increased Federal Funds: The Department of Developmental Services has done a tremendous job in expanding their Home and Community Based Waiver for individuals with developmental disabilities. **Opportunities also exist for the DMH to pursue a similar opportunity.**

Chapter 887, Statutes of 2002 (SB 1911, Ortiz), **directed the DMH to conduct an analysis**, contingent on receipt of funding for this purpose, **of expanding California's Home and Community-Based Waiver to include mental health services.** Given this fiscal environment, the DMH should be proceeding with this anyway.

Second, the DMH should also investigate whether California can obtain additional federal funds through the Medicaid Rehabilitation Option. It may be possible that some existing services could be included in this option in order to draw down additional federal funds.

Subcommittee Request and Questions: The Subcommittee **has requested the DMH to respond to the following questions:**

- **1.** Has the **DMH recently investigated the feasibility of increasing federal funds for any public mental health services?**
- **2. Has any work been conducted specifically regarding SB 1911 (Ortiz)?**

Budget Issue: Does the **Subcommittee want to direct the DMH to report back regarding the feasibility of obtaining increased federal funds?**

4. AB 3632, 1984 Mental Health Services to Special Education Pupils

Background—Mental Health Services to Special Education Pupils: Federal law (PL 94-142 of 1975-- the Education for All Handicapped Children Act—and the later **Individuals with Disabilities Education Act (IDEA)) mandates states to provide services to children enrolled in special education, including all related services as required to benefit from a free and appropriate education. Related services include mental health services**, occupational and physical therapy and residential placement.

In California, County MHPs are responsible for providing mental health services to students when required in the pupil's Individualized Education Program (IEP). This is because **AB 3632** (W. Brown), Statutes of 1984, **shifted responsibility for providing these services from School Districts and transferred them to the counties.**

These services are an entitlement and children can receive services irrespective of their parent's income-level. In addition, County MHPs cannot charge families for these services because the children are entitled to a free and appropriate public education under federal law.

What Mental Health Services Are Mandated: **Services to be provided, including initiation of service, duration and frequency of service, are included on the student's IEP and must be provided as indicated. Services can only be discontinued on the recommendation of the County MHP *and* the approval of the IEP team, or by parental decision.** Among other things, **mental health services** include assessments, and all or a combination of individual therapy, family therapy, group therapy, day treatment, medication monitoring and prescribing, case management, and residential treatment.

History of Funding for AB 3632 (Prior to 2002): For the past decade or so, **counties have paid** for the cost of the program **through a combination of the following:**

- **(1)** Categorical funding provided by the DMH as appropriated through the state budget process (about $12 million annually);
- **(2)** Mandate reimbursement claims as obtained via the State Commission on State Mandates process (referred to as the SB 90 process;

- **(3)** Realignment funds; and
- **(4)** Third-party health insurance when applicable, though parents can chose not to access their insurance for this purpose if they so decide (federal law).

It is estimated that about $100 million in total funds is expended annually.

Based on statistics from 2001-02, there are about 27,000 special education pupils who receive mental health services provided by County MHPs.

Budget Act of 2002 and AB 2781: The Budget Act of 2002 **eliminated the $12 million (General Fund) of categorical funding and directed the counties to obtain these funds through the mandate claims reimbursement process.**

As such AB 2781 (Section 38 of the legislation), the omnibus education trailer bill to the Budget Act of 2002, **requires the state to reimburse counties for all allowable costs incurred by counties in providing certain services to handicapped and disabled pupils. Reimbursement by the state would be provided either through the annual Budget Act or other statute.**

However, the Budget Act also placed a moratorium on all mandate reimbursement claims for local government, including funds provided for these mental health services to special education pupils. As such, no funds are available in the current year for this purpose, other than County Realignment funds.

In addition, counties have not been reimbursed for prior year claims for these services.

Further, **the statute provides that counties are not required to provide any share of these costs or to fund the cost of any part of these services with money received from the Local Revenue Fund** (i.e., County Realignment Funds) **for those reimbursement claims for services delivered in the 2001-02 fiscal year and thereafter to these pupils.**

Governor's Proposed Budget: The budget proposes to continue the **moratorium on all mandate reimbursement claims for local government, including funds provided for mental health services to special education pupils.**

At this time, it is unclear when the moratorium may end.

Summary of Constituency Concerns: The California Mental Health Directors Association (CMHDA) is **extremely concerned that funding for past claims have not been paid and that any future payment is unknown at this time (i.e., there is no statutory timeframe as to when mandate reimbursements will resume).**

Since July 1, 2002 counties have not received any funding for mental health services provided as an entitlement to special education pupils. According to the CMHDA, **counties must advance about $8 million per month (about $100 million annually) of County General Fund support**

to maintain these services. Further they contend that over $130 million is owed to counties for these services since the state has not yet paid claims from 2001-02 and some prior years.

Some counties may be able to provide some portion of funding for these services; **however, the CMHDA believes this would create a "catch-22" situation whereby if counties use County Realignment funds for this purpose, they may not submit mandate reimbursement claims for their costs. In addition, County Realignment funds are intended to serve their "target" population (low-income and uninsured population of children diagnosed as being Seriously Emotionally Disturbed).**

The CMHDA also states that a lack of funding is also causing service slow-downs in some areas and parents and Special Education Local Program Agencies (SELPAs) are becoming frustrated.

Subcommittee Staff Comment: California currently receives about $781 million in federal funds from the Individuals with Disabilities Education Act (IDEA), Part B grant. These funds are expended for a variety of special education functions. **According to recent federal funding information, California is slated to receive an increase of about $151.5 million (federal funds) in this grant for the budget year which will bring total funding to $933 million.**

A portion of these new federal funds may be available for expenditure for the mental health services provided by the counties for special education pupils. Based on current information, the provision of mental health services to special education pupils (i.e., a related service needed to ensure the success of the child's special education services) would be an appropriate expenditure of these funds, especially since these services are mandated by the IDEA.

It should be noted that California does have a federal "maintenance of effort (MOE)" problem with respect to the state's General Fund contribution to special education. Specifically, the state must increase General Fund support by $28.5 million or seek a federal waiver from this requirement. **As such, discussion regarding the full expenditure of the pending federal increase of $151.5 million will need to occur in a more comprehensive forum, such as in Senate Budget Subcommittee #1 which crafts the budget for education issues.**

Therefore, it is recommended to request Senate Budget Subcommittee #1 to place this issue on their agenda when special education issues are discussed. Specifically it would be to investigate the feasibility of funding these mental health services with IDEA, Part B, federal grant funds on a prospective basis (i.e., 2003-04 forward).

Subcommittee Request and Questions: The Subcommittee **has requested County Representatives as well as other interested parties, including parents, students, providers and advocacy groups to present their concerns. Further, the Subcommittee has requested the Administration (DMH and DOF) to provide any comment if desired.**

Budget Issue: Does the Subcommittee **want to request the Senate Budget Subcommittee #1 to discuss this issue in the context of special education funding priorities?**

5. Proposed Elimination of Funding for Early Mental Health Program (Proposition 98 Funds)

Background: Under the Early Mental Health Initiative, the state awards grants (for up to three-years) to Local Education Agencies (LEAs) to implement early mental health intervention and prevention programs for students in Kindergarten through Third Grade. Schools that receive grants must also provide at least a 50 percent match to the funding provided by the DMH. Schools use the funds to employ child aides who work with students to enhance the student's social and emotional development.

Students in the program are generally experiencing mild to moderate school adjustment difficulties. Students must have parental permission to participate in the program. In addition, all Early Mental Health Initiative programs are required to contract with a local mental health agency for referral of students whose needs exceed the service level provided in this program.

The Early Mental Health Initiative is an effective school-based program. **It serves children experiencing school adjustment issues who are *not* otherwise eligible for special education assistance or county mental health services because the student's condition is usually not severe enough to meet the eligibility criteria in these other programs (such as the Children's System of Care Program or EPSDT services).**

Governor's Mid-Year Reduction Proposal: The Administration proposed to revert $549,000 (Proposition 98 General Fund) in **unexpended** funds in 2002-03 and to eliminate the program in 2003-04 for savings of $15 million (Proposition 98 General Fund). **The Senate adopted the Mid-Year Reduction of $549,000 (Proposition 98 General Fund) but deferred action on the budget year proposal.**

Governor's Proposed Budget: The budget proposes to **(1)** eliminate the Early Mental Health Initiative for savings of $15 million (Proposition 98 General Fund), and **(2)** modify existing statutory language which would make the program subject to the availability of funding each year.

Staff Comment and Recommendation: Both the short-term and long-term effect of this reduction is that children with mild to moderate school adjustment problems will likely not receive services and may, as a consequence, need more intensive services later. Further, these students may end up doing poorly in school and developing other problems.

However, with this being a fiscal year where choices are difficult and triage must be done, it **should be noted that the Children's System of Care Program and the Early Periodic Diagnosis and Treatment (EPSDT) programs serve children with severe mental health needs,** where as the Early Mental Health Program serves children with school adjustment issues.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. Please provide a brief description of the proposal.**
- **2.** Could schools continue to provide these services using their Proposition 98 funds if they so choose?

Budget Issue: Does the Subcommittee want to adopt the Administration's budget proposal?

6. Early Periodic Screening Diagnostic and Treatment (EPSDT)—ISSUES "A" to "B"

Background—Overall: **Most children receive Medi-Cal services through the EPSDT Program**. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) **recipients under age 21 *any* health or mental health service that is medically necessary** to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, **including services not otherwise included in a state's Medicaid (Medi-Cal) Plan.**

Though the DHS is the "single state agency" responsible for the Medi-Cal Program**, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH)**. Further, **counties are responsible for providing, arranging and managing Medi-Cal mental health services under the supervision of the DMH and DHS. However, eligibility and the scope of services to which eligible children are entitled, are *not* established at the local level.**

Types of Services: The state uses the term **"EPSDT supplemental services**" to refer to EPSDT services which are required by federal law **but are not otherwise covered under the state Medi-Cal Plan for adults**. **Examples of services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.**

EPSDT Litigation: In 1990, a national study found that **California ranked 50th** among the states in identifying and treating severely mentally ill children. **Subsequently due to litigation (T.L. v Belshe' 1994)**, the DHS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court's conclusion **was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated.**

EPSDT Funding Process: The DHS and DMH **crafted an interagency agreement in 1995 to implement expanded services.**

Generally, this *original* agreement required County MHPs to provide a "baseline" amount using County Realignment Funds (essentially a county "maintenance-of-effort**") and then the state was responsible for providing the nonfederal share of the growth in the program.**

The baseline amount is established for each county based on a formula. **For 2003-2004, the baseline is $66.3 million plus an additional 10 percent county match ($5.9 million for the budget year) which was instituted in the Budget Act of 2002. The state will provide**

funding (via Medi-Cal) for costs above this amount (above the baseline and 10 percent match).

The General Fund dollars and accompanying federal matching funds are budgeted in the DHS and are transferred to the DMH as reimbursements. **The DMH distributes EPSDT funds to the County MHPs responsible for the provision of specialty mental health in each county. Final payment is based on cost settled actual allowable costs, or rates.**

Prevalence Rate for California: Based on a number of studies which estimate the prevalence of children exhibiting various levels of functional impairment, **it is estimated that 20 percent of children suffer from diagnosable mental disorder, and up to 13 percent of these children are estimated to be seriously emotionally disturbed. Given these estimates it is likely that between 500,000 to 1.3 million children and adolescents in California have a severe emotional disturbance.**

As a comparison, the statewide average EPSDT penetration rate is about 5.2 percent (as of 2001-02) for all ages. This varies from county to county and by age group. For example, for Los Angeles for children ages 9 to 17 years has a penetration rate of 7.7 percent, Sacramento has a rate of 9.4 percent and Solano has a rate of 8.7 percent for the same group.

It should be noted that the **Little Hoover Commission's report** (October 2001) on the existing inadequacies in the children's mental health system considered the potential savings if children's mental health utilization increased by 10 percent—the estimated prevalence rate. In one year, they estimated that California would save $44 million in juvenile justice, $27 million in CYA costs, $78 million in residential treatment and $1.4 million at Metropolitan State Hospital. **A total of $110 million in savings!**

Reasons Why Costs Continue to Increase: **A variety of factors have contributed to the continued expansion of EPSDT,** including legal decisions, recent Medi-Cal Program expansions, recent Medi-Cal reimbursement adjustments for Psychologist and Psychiatrist services, and the fact that several counties were delayed in initially expanding their EPSDT services in the first place.

It should be noted that when counties agreed to administer the EPSDT Program in 1995, a part of the understanding was that counties would endeavor to expand the program to meet the state's legal obligations under EPSDT (due to the litigation).

After the 2000 court decision regarding Therapeutic Behavioral Services (TBS), counties were once again urged by the state to act and assure that TBS services were available to any Medi-Cal eligible child in need of the service.

Further, in a 2001 report to the Legislature by the DMH entitled Utilization of the EPSDT Benefit, the DMH notes:

> "At least preliminarily, it appears that during the initial years of EPSDT implementation, County MHPs focused on increasing access to services for those EPSDT eligible children who needed

them; thus the number of clients served increased. **As the program has matured, counties are finding that they need to increase the intensity of services to many young clients with the most severe emotional disturbances in order to achieve positive outcomes and to keep youth in their homes, functioning in school and out of the juvenile justice system. This has resulted in higher paid claims per client in a number of counties that were unable to provide these levels of service prior to EPSDT."**

Budget Act of 2002—EPSDT Reductions: The Budget Act of 2002 **cut General Fund support by $35 million ($60 million total funds including federal funds) *and* required County MHPs to fund a 10 percent share-of-cost (equivalent to $5 million).**

The 10 percent county-share-of-cost was directed through a Governor's budget veto whereby he further reduced General Fund support and directed the DMH to obtain a 10 percent match from the counties.

In addition, trailer bill language was enacted which directed the DMH to assist counties in implementing managed care principles that would help slow the growth in the program. The DMH is proceeding with some steps to implement these provisions to curtail growth in the program (As discussed in Issue "A", below).

ISSUE "A"—Update On Cost Containment, including Regulations

Background—Statutory Authority: As discussed above, trailer bill language was enacted with **the Budget Act of 2002 which directed the DMH to assist counties in implementing managed care principles that would help slow the growth in EPSDT.** This language however, did not provide the DMH with any emergency regulation authority. Instead on their own, the DMH opted to use emergency regulation authority provided to the DHS for Medi-Cal fraud and abuse purposes which was contained in AB 1107, Statutes of 1999, the omnibus health trailer bill for the Budget Act of 1999.

It should also be noted that the **DMH has authority to conduct audits and reviews of counties and EPSDT providers** that contract with counties to deliver the services. In addition, the state (DMH and DHS) **can if needed, stop county MHP or provider payments, reclaim funds already paid, and seek program changes to remedy their findings.**

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please provide **a brief description of the various cost containment reviews** (such as the field audits) **and measures** implemented, including the development of emergency regulations for **Day Treatment Services** and actions taken regarding **Therapeutic Behavioral Services** (TBS).
- **2. When will emergency regulations be in place**?

ISSUE "B"—Proposed Change in EPSDT Funding Methodology

Background & Governor's Proposed Budget: In an effort to more accurately estimate EPSDT expenditures, the DMH has changed its methodology for estimating budget year needs. **On key change is that DMH's revised method takes into account specific data on EPSDT growth trends in *each* county**, while the previous expenditure projection method was based on cost data that was aggregated on a statewide basis.

The budget requests **an increase of $150 million ($142.4 million in Reimbursements from the DHS of which $69.7 million is General Fund and $72.7 million is federal Medicaid funds, and $7.5 million in County Realignment funds) for the EPSDT Program, including Therapeutic Behavioral Services (TBS).** This increase reflects a proposed change in estimating methodology by the Administration in an effort to more accurately reflect expenditures.

The Department of Finance states that the full effect of cost control measures implemented by the Legislature through AB 442, Statutes of 2002, trailer bill to the Budget Act of 2002, will not be realized until 2004-05. **However, the proposed $230.4 million increase does assume a smaller growth rate.**

Legislative Analyst's Office Recommendation: Though the LAO **concurs that the new methodology is consistently more accurate based on historical data, they are recommending a reduction of $25 million ($11.7 million General Fund) from the budget since they believe the new methodology may error on the side of providing too much funding.**

Subcommittee Request and Questions: The Subcommittee has requested for the DMH to respond to the following questions:

- **1. DMH,** Please provide a overview of the new methodology and why you believe it will more accurately reflect expenditures.
- **2. LAO**, Please explain your recommended reduction.
- **3. DMH** Please respond to the LAO concerns.

Budget Issue: Does the Subcommittee **want to adopt the LAO reduction or approve as budgeted**?

7. The Administration's Proposed Realignment & the LAO Realignment Option

Governor's Proposed Budget—Summary Overall: The Governor's proposed Realignment package consists of **four components in the health and human services area (over $7.9 billion), plus a court security plan for the Trial Courts ($300 million), for total expenditures of $8.2 billion.** The proposed new dedicated Realignment **revenues would stream from an increase in the Sales Tax (one percent), an increase in Personal Income Tax (10-11 percent bracket) and an increase in the Tobacco Excise Tax ($1.10 increase).**

The Administration proposes trailer bill legislation for each of these components. At this juncture, **the language is crafted broadly** to express the Legislature's intent to enact legislation to **(1)** transfer the specified program and its non-federal share of expenditures, **(2)** maintain state oversight of said programs, and **(3)** become operative only if dedicated revenues are enacted for this purpose.

The proposal assumes that 2003-04 fiscal allocations to counties would be based on the proposed level of funding for counties for each of the programs, absent Realignment, in order to avoid program disruptions in the budget year. However for 2004-05, the Administration assumes that a single allocation would be made to counties based on a formula to be developed through discussions. **As such, this would potentially serve as a type of "block grant" to the counties whereby the counties could conceivably shift funding across programmatic areas.**

The Legislature may want to consider several factors when reviewing this proposal. First, any transfer of program and fiscal responsibility should be designed to assist both the state and counties in maximizing their service delivery responsibilities. If service delivery is maximized, the program participants will likely be better served and program efficiencies will more likely occur.

Second, the dedicated revenues provided for the program transfers should have a growth rate that is comparable with the anticipated growth of the program being transferred. If this is uncertain, a trigger mechanism should be considered in order to bring forth an expenditure or revenue discussion. The Realignment of 1991-92 included a "poison pill" provision for this purpose.

Third, the programs transferred should be programs that allow counties and constituency groups flexibility to craft innovative approaches that utilize community-based resources and services. Under the Realignment of 1991-92, mental health services were re-focused and shifted from a model heavily reliant on state hospital services to a model that now offers a broader array of community based options. Both fiscal incentives and policy flexibility were made available to allow for innovation and some experimentation.

Governor's Proposed Budget—Mental Health: The Realignment package includes a $306 million component for Mental Health and Substance Abuse, including local programs for drug and alcohol services (Proposition 36 funding), the Integrated Services for Homeless Adults, the Children's System of Care Program, and Drug Courts.

Of this $306 million amount, **the total amount that affects mental health is $74.9 million. Specifically, it proposes to shift $74.9 million in expenditures for the Integrated Services to the Homeless Program and the Children's System of Care Program to the counties.**

In addition, the budget assumes a reduction of 8 positions for savings of $616,000 (General Fund) from the DMH state support. This reduction assumes elimination of 3 positions for the Children's System of Care Program and 5 positions for the Integrated Services for the Homeless Program.

Background—What are the Programs Proposed in Governor's Realignment: In 1988, the Wright, McCorquodale, Bronzan Act (AB 3777) established reforms regarding services to adults with serious mental illness. **It set forth a "systems of care" service delivery model** whose core elements include consumer and family focused services, a personal service plan, and the delivery of services that are measurable and accountable. **From this original concept the Children's System of Care Program evolved, as well as the Integrated Services to the Homeless Program.**

The **Children's System of Care Program targets** adolescents 18 years of age and under who have a diagnosed mental disorder in which the disorder results in substantial impairment in two or more areas (such as self care, school performance, family relationships and ability to function in the community). Services are provided in an integrated manner and include family participation. **Evaluations of the program have shown that the program is highly successful and cost-beneficial (including savings in service expenditures for group homes, special education and juvenile justice).**

The Integrated Services to the Homeless Program. (AB 34, Steinberg) focuses on people who are frequently homeless and/or incarcerated and who have little or no access to existing service programs. The intended clients of this model are adults who have needs in many areas such as food, shelter, employment and rehabilitative services, as well as treatment. Many of these adults don't have access or don't meet eligibility requirements for traditional mental health programs. Once identified, these adults are given access to a comprehensive service structure. **This program has had at least two evaluations that have shown its efficacy and cost-benefit to the state and counties.**

Budget Act of 2002—Reduced the Children's System of Care and AB 34 Projects: The **Governor vetoed (1)** $13.8 million General Fund from the Children's System of Care Program, **(2)** $10 million General Fund from the Integrated Services for Homeless Adults Program, and **(3)** $2.5 million from the Adult Systems of Care Projects (which eliminated all remaining funding).

These vetoes left $20 million (General Fund) available for expenditure for the Children's System of Care Program and $

Subcommittee Staff Comment Regarding Governor's Proposal: Shifting responsibility for fully operating the Children's System of Care Program as well as the Integrated Services for Homeless Adults Program makes sense if **(1)** a reliable revenue source is provided to fund the

programs, and **(2)** some level of additional funding is provided to assist in making the programs whole from the budget reductions taken by the Governor's vetoes. These two programs offer the counties flexibility in operation and compliment the existing mission of the County MHPs.

Legislative Analyst's Realignment Option—Much Broader: The LAO has offered a much broader "option" for consideration. **Under her realignment proposal the following mental health programs are offered to be shifted to the counties:**

- Early Periodic Screening, Diagnosis and Treatment (EPSDT);
- Medi-Cal Mental Health Managed Care;
- Mental health local mandates, including AB 3632 services to special education pupils;
- Ancillary services (meaning medical health care-related services) for individuals in Institutions for Mental Disease (IMDs); and
- Community services for brain-damaged adults (i.e., "Caregiver Resource Centers").

Constituency Group Concerns: **Many constituency groups, as well as the DMH**, **have raised significant issues** with respect to the LAO proposal.

With respect to EPSDT, there are considerable concerns. Generally, EPSDT has broad requirements given past litigation, federal mandates and state requirements. There would not be much, if any, county flexibility. Further, EPSDT penetration rates are still relatively low and pressures with litigation, the lack of growth in County Realignment Funds and the need for more intensive services is a recipe for extensive concerns and potential disaster.

With respect to ancillary services, the physical health care needs of individuals under age 65 living in long-term care facilities are paid from state-only Medi-Cal funds by the DHS. County MHPs are not presently responsible for physical health care needs. They would have to establish relationships with the full range of physical health care providers, authorization systems and payment mechanisms. It should be noted that this particular population is usually very medically involved.

With respect to the Caregiver Resource Centers, these programs are direct contractors to the state for supportive services to caregivers of individuals with brain injury, primarily dementias. **This would be a new population for the counties to serve and currently, most of the services provide to this population are not the responsibility of counties.**

Budget Issue: Does the **Subcommittee want to (1)** back out the Governor's Realignment proposal in order to have a level playing field to begin overall restructuring/realignment discussions, **(2)** adopt the Governor's mental health proposal, or **(3)** craft another option?

8. Children's System of Care Program(CSOC) –Update on New Data Outcomes

Background: Existing law authorizes counties to develop a comprehensive, coordinated children's mental health service system as provided under the Children's Mental Health Services Act.

The purpose of the program is to develop an integrated system of care for children who are severely emotionally and behaviorally disturbed, and their families. **The basic elements of the program include interagency coordination and collaboration, child/family-centered services, culturally competent services, and case management services.** Families of the children are full participants in all aspects of the planning and delivery of services.

The target population includes individuals 18 years of age and under who have a diagnosed mental disorder in which the disorder results in substantial impairment in two or more areas (such as self care, school performance, family relationships and ability to function in the community).

Under the program, accountability of services is required through measurable performance outcome goals. An evaluation of the program generally concluded that the program has been **very successful and cost-beneficial, including savings in service expenditures for group homes, special education, and juvenile justice.**

Recent Funding History: **The Legislature has been very supportive of the program in the past**. Legislative budget augmentations to facilitate statewide expansion have included **(1)** $1.9 million in 1995, **(2)** $7.1 million in 1996, **(3)** $6 million in 1997, **(4)** $20 million in 1998 which was reduced by Governor Wilson to a total of $4 million, **(5)** $13.4 million in 1999 which was reduced by Governor Davis to a total of $2 million, **(6)** a veto of $2.1 million (General Fund) by Governor Davis in 2001, and **(7) a veto of $15.8 million ($13.8 million General Fund and $2 million federal SAMHSA block grant funds) by Governor Davis.**

Governor's Veto Message—Develop New Data System: In his **veto message** that accompanied the Budget Act of 2002, **the Governor directed the DMH to restructure the program t provide better accountability and documented cost savings.**

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. DMH**, **Please briefly describe what restructuring has occurred** with respect to the Children's System of Care Program.
- **2. DMH**, Please **briefly describe what data has been obtained from the counties** and what your preliminary thoughts are about the data.
- **3. When will information be available for review by the Legislature**?
- **4.** With respect to the $**2 million in federal SAMHSA funds that was vetoed by the Governor in the Budget Act of 2002, have those unexpended federal funds been allocated to the counties as yet? If not, why not?**

9. Second Level Treatment Authorization Request Appeals.

Background: Existing state regulation (Title 9, Section 1850.305) provides that **a psychiatric hospital may file a second level TAR appeal when payment issues have not been resolved at the first level appeal (between the hospital and a County Mental Health Plan).**

Typically, a second level TAR appeal involves disagreements between a hospital (non-county owned or operated facility) and a County Mental Health Plan regarding the number of bed days the county will reimburse. For example, a hospital claims 15 days of inpatient services for a particular client and the County Mental Health Plan will only approve 10 days. As such, the hospital appeals the additional 5 days to the state. The state can either agree or disagree with the hospital. According to DMH statistics, the DMH agrees with County Mental Health Plans about 88 percent of the time.

It should also be noted, that the DMH's role in the second level TAR appeals process has inserted the department into judicial disputes between hospitals and County Mental Health Plans. According to the DMH, 29 lawsuits have been filed in this area.

Governor's Mid-Year Reduction and Proposed Budget: The Administration proposed to eliminate the second level Treatment Authorization Request (TAR) appeals process for savings of $64,000 General Fund in 2002-03 and savings of $126,000 (General Fund) in 2003-04. The savings comes from the elimination of two state positions. The Legislature denied the request for the Mid-Year Reduction.

No trailer bill language has been proposed for this action.

Constituency Concerns: County MHPs are concerned about this proposal because hospitals who want to appeal a County MHP denial of payment can go directly to the courts, and the DMH would no longer be involved in the case.

Subcommittee Staff Comment: The Administration's proposal continues the Administration's direction to further reduce the state's role in providing oversight of mental health services. In this case, oversight of inpatient hospital psychiatric services. **This is really a policy area that needs to be clarified more, rather than a fiscal, budgetary issue. Broader policy issues exist that affect the provision of inpatient psychiatric services and the payment for them.**

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please explain your proposal and why the DMH should not be engaged in conducting secondary TAR appeals.

Budget Issue: Does the Subcommittee want to **(1)** require the DMH to introduce a policy bill so a comprehensive policy discussion can occur regarding the proposal, **(2)** reject the Governor's proposal, **(3)** adopt the Governor's proposal, or **(4)** create another option?

B. State Hospitals

Summary of Funding

Overall Background for the State Hospital Budget: The budget proposes **expenditures of $660.4 million ($513.4 million General Fund) for the State Hospitals for a *net* increase of almost $15.4 million (increase of $18 million General Fund and a decrease of $2.6 million in County Realignment funds) over the revised 2002-03 budget.**

Further, an appropriation of $21.5 million ($736,000 General Fund and $20.8 million Public Building Construction Fund) is provided for capital outlay purposes.

Summary of Caseload

State Hospital Population—Overwhelming Majority Are Penal Code: The DMH estimates **a population of 4,640 patients** for 2003-04 (as of June 30, 2004) **at the four State Hospitals -- Napa, Metropolitan, Patton, and Atascadero**. Of this population, **almost 84 percent of the beds are designated for penal code-related patients** and 16 percent are to be purchased by the counties (i.e., Lanterman-Petris-Short beds), primarily Los Angeles County.

Who Are the Penal Code Patients: **Penal Code-related patients include individuals who are classified as (1)** not guilty by reason of insanity (NGI), **(2)** incompetent to stand trial (IST), **(3)** mentally disordered offenders (MDO), **(4)** sexually violent predators (SVP), and **(5)** other miscellaneous categories. The basic goal of the program is the restoration of a patient's optimal level of functioning to allow reentry into the community or the criminal justice system as appropriate.

Based on recent statistics, about 2,966 patients, or 62 percent, of the State Hospital patients have a diagnostic category of Schizoaffective Disorder, including Paranoid Schizophrenia. With respect to legal commitment categories, about 26 percent of the total patient population is Incompetent to Stand Trial, 25 percent is Not Guilty by Reason of Insanity, and 18 percent are Mentally Disordered Offenders. Only 18 percent of the patients were county commitments, with only 39 patients voluntarily committing themselves.

ITEMS FOR DISCUSSION

1. State Hospital Patient Population & Operating Expenses—Proposed Increase

Background--Current Year Section Letter Denied by Legislature: The DMH submitted a current year (2002-03) deficiency requesting an increase of $2.9 million (General Fund) due to an increase of 27 patients classified as Medically Disorder Offenders (MDO) at the State Hospitals. **The Joint Legislative Budget Committee denied this request because the overall patient caseload had not increased, only the MDO patients. Specifically, the number of beds needed for other patient categories was below the current-year budget level. As such a deficiency request was not justified to provide at this time.** Further, since the May Revision

will provide an update in caseload for both the current year and budget year, it was determined to wait and see how the current year caseload progresses.

Governor's Proposed Budget—Too High: The DMH estimates a population of **4,640 patients** for the budget year which reflects **a proposed increase of 115 patients over the Budget Act of 2002 patient population** of 4,525 patients. **However, the proposed budget estimate assumed that the population trend proposed in the current-year section letter (see above) would continue and increase into the budget year; subsequently, it is overstated.**

The budget proposes a **net increase of $15.4 million (increase of $18 million General Fund and a decrease of $2.6 million County Realignment Funds) for an increase of 88 patients over the proposed revised 2002-03 budget *and* an increase for operating expenses and equipment (OE&E). Specifically, the DMH is seeking an increase of $8.5 million (General Fund) for the caseload and $9.5 million (General Fund) for the OE&E.**

The DMH contends that funds are needed for OE&E, such as for patient drugs, food, utilities, outside medical services and related items. The DMH notes that the State Hospital OE&E budget for 2001-02 spent about $11.4 million more than expected and as such, needs additional funding in this area to compensate for increased expenditures and usage for some of the OE&E items. **They note that their requested increase of $11.4 million ($9.5 million General Fund) is preliminary and that a revision on this estimate may be forthcoming at the May Revision.**

The proposed caseload for each State Hospital is as follows:

Hospital & Patient Type	Budget Act of 2002	Proposed Current Year	Revised 2002-03	Proposed Adjustment	Proposed 2003-04
Atascadero	**1,187**	**12**	**1,199**	**33**	**1,232**
Sexually Violent Predators	506		506	33	539
Penal Code	681	12	757		693
Metropolitan	**833**	**10**	**843**	**4**	**847**
County Patients	457		457	-16	441
Penal Code	376	10	386	20	406
Napa	**1,201**	**1**	**1,202**	**38**	**1,240**
County Patients	240		240	-10	230
Penal Code	961	1	962	48	1,010
Patton	**1,304**	**4**	**1,308**	**13**	**1,321**
County Patients	79		79		79
Penal Code	1,225	4	1,229	13	1,242
TOTALS	**4,525**	**27**	**4,552**	**88**	**4,640**
• **LPS**	**(776)**	**(0)**	**(776)**	**(-26)**	**(750)**
• **Penal**	**(3,749)**	**(27)**	**(3,776)**	**(114)**	**(3,890)**

Legislative Analyst's Office Recommendation—Reduce Funding: The LAO notes that more recent patient population data indicates that patient population growth for other categories of patients is not materializing. Specifically, the patient population as of December 2002 was 4,238—a net drop of 12 patients since current-year began. They believe this trend suggests that the budget year request is significantly overstated.

In addition, the LAO notes that the DMH has many vacancies at the State Hospitals which raises the question as to whether the DMH can fund some of the OE&E expenditures from salary savings. (This was done in 1999-2000 when a similar situation was occurring.) **The LAO also raises the issue as to whether the State Hospitals should be restructured to abolish certain vacant positions and to permanently shift personnel dollars to fund OE&E expenditures.**

As such, the LAO recommends to reduce the caseload funding by $14.1 million General Fund, and corresponding special funds to reflect lower caseload adjustments.

Subcommittee Request and Questions: The Subcommittee has requested the DMH and LAO to respond to the following questions:

- **1. DMH**, Please provide a brief summary of the patient population funding request, including how the OE&E was calculated.
- **2. DMH, Will this be updated at the May Revision and is it likely that a decrease will be proposed?**
- **3. DMH, How does your OE&E estimating process compare with that used by the Department of Developmental Services for the state Developmental Centers?**
- **4. LAO, Please explain your recommendation to reduce by $14.1 million (General Fund), and your concerns with the OE&E methodology.**
- **5. LAO, Have you looked at what it could mean to consolidate the State Hospitals within the Department of Developmental Services since they operate the Developmental Centers? (At one time the State Hospitals and Developmental Centers were operated by the same state department.)**

Subcommittee Staff Recommendation: It is **recommended to (1)** adopt the LAO reduction of $14.1 million (General Fund), pending receipt of the May Revision, **(2)** direct the LAO to work with the DMH to craft a **restructuring proposal to improve accountability and more accurately reflect expenditures for OE&E and caseload be presented to the Subcommittee prior to the May Revision which,** and **(3)** direct the DMH to prepare the State Hospital budget for 2004-05 as a comprehensive "estimates" package, as presently done by the Department of Developmental Services for the state-operated Developmental Centers.

Budget Issue: Does the **Subcommittee want to (1)** adopt the Subcommittee staff recommendation, **(2)** want until the May Revision for revised patient caseload and OE&E expenditures, **or (3)** some other combination?

2. Administration Sponsored Language Regarding State Hospital Patient Population—*Informational*

Background: The Administration has sponsored language, as contained in AB 941 (Yee) as introduced, which among other things would modify the agreement crafted in 1997 regarding Napa State Hospital.

The original agreement contained in trailer bill legislation that accompanied the Budget Act of 1997 enabled the DMH to begin housing a significant level of Penal Code patients at Napa State Hospital. Specifically, it allowed up to a maximum of 980 Penal Code beds or about 80 percent of the total hospital beds at the facility.

This original agreement was arduously crafted after numerous community meetings and budget hearings.

The intent of this language was to ensure (1) the safety of the greater Napa community by requiring that if a significant number of Penal Code patients were to be housed at Napa that they be provided treatment in a secured setting (i.e., considerable security measures were specified), **(2)** that counties still had access to the hospital to make civil commitments and **(3)** that the Penal Code patient population would not exceed 980 beds.

Proposed Language Change: Among other things, the Administration is proposing to amend Section 7200.06 (a) of Welfare and Institutions Code pertaining to the original Napa agreement as follows (proposed changes shown in strike out and underline):

> (a) Of the total ~~**patient population residing**~~ **of 1,362 licensed beds** at Napa State Hospital **at least 20 percent of these beds shall be available** in any given fiscal year, ~~**not more than 80 percent shall be patients whose placement has been required pursuant to the Penal Code**~~ **for use by counties for contracted services.**
>
> (b) After construction of the perimeter security fence is completed at Napa State Hospital, no patient whose placement has been required pursuant to the Penal Code shall be placed outside the perimeter security fences, with the exception of placements in the General Acute Care and Skilled Nursing Units. The State Department of Mental Health shall ensure that appropriate security measures are in place for the general acute care and skilled nursing units.
>
> (c) After construction of the perimeter security fence is completed at Napa State Hospital, in no case shall the population of patients whose placement has been required pursuant to the Penal Code exceed 980.

According to the Administration, there are now only 224 county-purchased beds being used at Napa, or just **over 16 percent** (versus the original 20 percent). (This is due to the declining use of beds being purchased by the counties for civil commitments.) **As such, the Administration contends it needs to modify the statute in order to be able to fully use the 980 Penal Code beds. Specifically they note that as the number of county-purchased beds**

declines, fewer authorized beds are available for the Penal Code patients. Therefore the language change is desired to maintain the 980 beds.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. DMH**, **has the Napa Community been contacted** regarding this proposed change to the carefully crafted original agreement? If so, whom?
- **2. DMH**, Please explain your proposal ***and*** any proposed changes you would like to make to the language.

Budget Issue: Does the **Subcommittee want to direct the DMH to work with the Napa Community and representatives from the area to ensure that the language is clear and that the intent of the language does not result in budget issues regarding the allocation of patients, staff or other related resources?**

3. Salinas Valley State Prison—Another Delay

Background and Governor's Budget Proposal: The Budget Act of 2002 and a subsequent adjustment provided $5.4 million (General Fund) support to the California Department of Corrections (CDC), with an equivalent amount of Reimbursement authority to the DMH to open a 64-bed psychiatric facility at Salinas Valley State Prison.

The Governor's budget proposes to provide full-year funding of $7.2 million for the operation of the facility, plus an augmentation to the CDC budget of $100,000 for various additional operating expenses.

Comparable to a longstanding arrangement between the two departments at the California Medical Facility at Vacaville, the new Salinas Valley Facility will be staffed and managed by the DMH to exclusively serve CDC inmates at the prison.

Legislative Analyst's Office Recommendation: The LAO recommends that the General Fund budget for the **CDC be reduced by $1.5 million, with an equivalent reduction to reimbursements in the DMH budget, to reflect savings from the delay in the activation of the new mental health unit at Salinas Valley Prison. In addition, the LAO notes that the CDC will present additional adjustments at the May Revision.**

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. DMH,** Please explain you proposal.
- **2.** LAO, Please explain your concerns.
- **3.** DMH, and respond to the LAO recommendation.

Budget Issue: Does the Subcommittee want to adopt the LAO recommendation and also discuss an additional adjustment at the May Revision?

MAJOR SOURCES OF PUBLIC MENTAL HEALTH FUNDING

	Realignment	Medi-Cal	CalWORKS	EPSDT	Integrated Services--Homeless Adults	Children's System of Care	Healthy Families Program
Purpose	Provides **medically necessary** mental health services to *target population, to the extent resources are available.*	Provides **medically necessary** psychiatric inpatient hospital, rehabilitative services and case management.	Reduces mental health barriers to employment.	Provides **medically necessary** specialty mental health services, such as behavior management modeling, medication monitoring, family therapy, and crisis intervention	Provides mental health services to homeless persons, parolees and probationers with serious mental illness.	Provides mental health services to children who are seriously emotionally disturbed.	Provides *supplemental* mental health services to children who are seriously emotionally disturbed.
Eligibility	Services provided on a sliding fee basis.	Enrolled in Medi-Cal.	Temporary Assistance for Needy Families (TANF) recipient.	Enrolled in Medi-Cal.	Adults with severe mental illness who are homeless, at risk of becoming homeless, recently released from jail.	Enrolled by county	Enrolled in Healthy Families Program and referred to that county.
Age Limits	None.	None.	16 (if not in school) through 59 years. Voluntary after age 59.	Under age 21 years	None.	Under age 21 years	Birth to 19 years
Severity of Disability	Focuses mainly on people with **serious and/or persistent mental illness** or serious emotional disturbance.	Requires a diagnosis of **severe impairment** in life functioning and not responsive to physical health care based treatment. Includes episodic users as well as people with serious disabilities.	Based on whether mental health is barrier to employment rather than severity of mental illness. Expect broad range of disability.	Requires determination of being **"medically necessary"** to correct or ameliorate a mental illness or condition. Includes episodic users as well as people with serious disabilities.	Focuses mainly on people with **serious and/or persistent mental illness**	**Serious emotional disturbance**.	**Serious emotional disturbance**.
Type of Funding	County Realignment Funds—Mental Health Subaccount—which consists of state sales tax and vehicle licensing fees.	Depending upon the service being provided, either Realignment funds or state General Fund moneys are used to draw a federal match.	For Medi-Cal eligible services, state General Fund moneys from an annual allocation amount (part of State's MOE for TANF).	Realignment funds are used up to a baseline amount established for each county and then state General Fund moneys are used beyond the baseline. These funds are used to draw a federal match.	State General Fund ($54.8 million)	State General Fund $20 million	Realignment Funds are used to draw a federal match.
Federal Funds	None.	About 50% match.	No. State's MOE to maintain federal TANF funds.	About 50% match.	None	None.	About 65% match.

Prepared by Diane Van Maren, Senate Budget & Fiscal Review Committee **March 10, 2003**